Dr. Olinka Hrebicek
Neurology

Please answer the following questions:

E-mail: ______________________________ **GP/Walk-in clinic**: __________________________

Name: _______________________________ Age: _______ Height: _______ Weight: _______
Handedness: [ ] Right [ ] Left
What is/was your occupation: ____
Are you married/live with a partner? [ ] Yes [ ] No. How many children do you have? _____
Neurological concerns (**why** you are here today and **when** did the problem start):

Please put an "X" beside the conditions/illnesses you have had:

[ ] Anxiety	[ ] Head injuries	[ ] Lupus
[ ] Arthritis	[ ] Heart disease	[ ] Migraine headaches
[ ] Asthma	[ ] Hepatitis	[ ] Peptic ulcer disease
[ ] Bleeding tendency	[ ] High blood pressure	[ ] Pneumonia
[ ] Blood clots	[ ] High cholesterol	[ ] Sleep apnea
[ ] Cancer	[ ] HIV	[ ] STI __________________
[ ] Depression	[ ] Hypothyroidism	[ ] Stroke
[ ] Diabetes	[ ] IBD/Crohn's disease	[ ] Tuberculosis
[ ] Drug addiction ___________	[ ] Jaundice	[ ] Other ________________
[ ] Glaucoma	[ ] Kidney disease	_________________________

How much alcohol do you consume in a week? _________. Have you quit previously? _______
Do you smoke? _________. If you have quit, when? __________
Recreational drug use: [ ] never [ ] now [ ] in the past: which drugs _________________

Previous injuries: ____

List all prescription medications (<u>including all dosage details</u>) you currently take:

Pharmacy Name/Location/Telephone:

List any over-the-counter drugs, supplements, herbs, or vitamins that you take: ______________
____

List medication **allergies** and reactions (i.e. rash) you have had: __________________________
____

List any significant diseases that run in your family (i.e. diabetes, strokes, migraines, neurological diseases): ____

"Review of Systems"

Have you had any of the following recently (**please indicate with an "X"**)?

Cardiovascular
[ ] palpitations
[ ] blue painful hands
[ ] feeling faint
[ ] chest pains

Constitutional
[ ] weight loss
[ ] loss of appetite
[ ] fever
[ ] night sweats
[ ] headache
[ ] fatigue
[ ] heat or cold intolerance
[ ] sleep changes such as insomnia, vivid dreaming and/or acting out

ENT
[ ] deafness
[ ] spinning dizziness
[ ] ringing in the ears
[ ] discharge from the ears
[ ] nasal bleeding
[ ] trouble swallowing
[ ] change in your voice
[ ] pain chewing food
[ ] sinus problems
[ ] loss of smell/taste
[ ] dry mouth

Eyes
[ ] eye pain
[ ] tearing

Gastrointestinal
[ ] diarrhea
[ ] vomiting
[ ] swallowing problems
[ ] black stool
[ ] blood in your stool
[ ] loss of bowel control/constipation

Genitourinary
[ ] loss of bladder control
[ ] urinating too frequently
[ ] getting up at night to urinate
[ ] pain when urinating
[ ] blood in the urine
[ ] impotence/sexual dysfunction
[ ] menstrual change

Hematologic
[ ] bruising
[ ] easy bleeding
[ ] frequent infections

Musculoskeletal
[ ] arthritis
[ ] joint pain/ache
[ ] muscle pain/ache
[ ] change in size of feet/hands

Neurologic
[ ] mood change
[ ] depression/anxiety
[ ] tingling in the arms/legs
[ ] memory loss or slowed thinking
[ ] reduced arm swing while walking
[ ] change in handwriting
[ ] shaking of the hand(s), arm(s), leg(s), lips, or jaw while at rest or with action

Respiratory
[ ] shortness of breath
[ ] wheezing

Skin
[ ] rash
[ ] breast lump
[ ] breast discharge/milk
[ ] hair loss
[ ] pain combing your hair
[ ] coloured spots on your skin

PHQ-9 – Nine Symptom Checklist

Name: ______________________________________ Date: ______________________

Over the last **2 weeks**, how often have you been bothered by any of the following problems?

1. Little interest or pleasure in doing things
[ ] Not at all [ ] Several days [ ] More than half the days [ ] Nearly every day

2. Feeling down, depressed, or hopeless
[ ] Not at all [ ] Several days [ ] More than half the days [ ] Nearly every day

3. Trouble falling or staying asleep, or sleeping too much
[ ] Not at all [ ] Several days [ ] More than half the days [ ] Nearly every day

4. Feeling tired or having little energy
[ ] Not at all [ ] Several days [ ] More than half the days [ ] Nearly every day

5. Poor appetite or overeating
[ ] Not at all [ ] Several days [ ] More than half the days [ ] Nearly every day

6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down
[ ] Not at all [ ] Several days [ ] More than half the days [ ] Nearly every day

7. Trouble concentrating on things, such as reading the newspaper or watching television
[ ] Not at all [ ] Several days [ ] More than half the days [ ] Nearly every day

8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual
[ ] Not at all [ ] Several days [ ] More than half the days [ ] Nearly every day

9. Thoughts that you would be better off dead or of hurting yourself in some way
[ ] Not at all [ ] Several days [ ] More than half the days [ ] Nearly every day

If you checked off <u>any</u> problems, how <u>difficult</u> have these problems made it for you to do your work, take care of things at home, or get along with other people?
[ ] Not at all [ ] Several days [ ] More than half the days [ ] Nearly every day

GAD-7 Screening Questions

Name: ____ Date: ______________________

During the last **2 weeks**, how often have you been bothered by the following problems?

1. Feeling nervous, anxious, or on edge
[ ] Not at all [ ] Several days [ ] More than half the days [ ] Nearly every day

2. Not being able to stop or control worrying
[ ] Not at all [ ] Several days [ ] More than half the days [ ] Nearly every day

3. Worrying too much about different things
[ ] Not at all [ ] Several days [ ] More than half the days [ ] Nearly every day

4. Trouble relaxing
[ ] Not at all [ ] Several days [ ] More than half the days [ ] Nearly every day

5. Being so restless that it is hard to sit still
[ ] Not at all [ ] Several days [ ] More than half the days [ ] Nearly every day

6. Becoming easily annoyed or irritable
[ ] Not at all [ ] Several days [ ] More than half the days [ ] Nearly every day

7. Feeling afraid, as if something awful might happen
[ ] Not at all [ ] Several days [ ] More than half the days [ ] Nearly every day

If you off checked any problems, how difficult have they made it for you to do your work, take care of things at home, or get along with other people?
[ ] Not difficult at all [ ] Somewhat difficult [ ] Very difficult [ ] Extremely difficult